Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
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Original Public Report

Report Issue Date: May 18, 2023	
Inspection Number: 2023-1515-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: The Wexford Residence Inc.	
Long Term Care Home and City: The Wexford, Scarborough	
Lead Inspector Nital Sheth (500)	**Inspector Digital Signature**
Additional Inspector(s) Yannis Wong (000707)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8-11, 12 (off-site), 15, 2023.

The following intake(s) were inspected:

- An intake related to fall in incident resulting in injury
- An intake related to skin care concerns.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

1) The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
The Ministry of Long-term Care (MLTC) received a complaint raising concerns related to resident #001's skin care abuse, and neglect.

Resident #001 had a risk for skin integrity related to the resident's health condition. The resident had history of impaired skin integrity. The care plan indicated the staff to apply an identified device in a specified location to prevent impaired skin integrity.

The inspector observed resident #001 in the specified location without having the identified device.

PSW #105 indicated that someone might have removed the identified device for a specific purpose, but one should have been made available. PSW #105 and the DOC acknowledged that the resident should always have the identified device applied while in the specified location.

Missing the identified device while in the specified location, had placed the resident at risk of potential injury to their skin.

Sources: Resident #001's care plan, observation, interviews with PSW #105 and the DOC. [500]

2) The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Rationale and Summary:
(a) On two different occasions, resident #002 was not in a specified location and a specific intervention was observed to be implemented.

Resident #002 was at moderate risk of falls. Their care plan identified that the specific intervention should be removed during specified period and applied during other periods as a part of the fall prevention interventions.

On first occasion, PSW #110 acknowledged that the specific intervention should have been removed when the resident was not present in a certain location. On second occasion, the specific intervention was inappropriately applied when the resident did not require it.

The physiotherapist (PT) and DOC confirmed that the specific intervention was a part of the resident's fall prevention intervention, and the staff were expected to remove it, when the resident was not present in a certain location. The PT and DOC acknowledged the specific intervention could be a hazard for the resident when it was not applied appropriately.

Not removing the specific intervention when the resident was not in the specific location, placed the resident at risk for a fall and potential injury.

Sources: Observations (two different occasions); resident #002's clinical records, interviews with PSW #110, PT, and DOC.

(b) Resident #002 was observed on two different occasions utilizing an inappropriate intervention.

Resident #002's care plan identified that the resident should use the appropriate falls prevention intervention.

During an interview with Registered Practical Nurse (RPN) #113, they confirmed that the resident was not utilizing the appropriate falls prevention intervention.

The PT and DOC confirmed that the inappropriate falls intervention applied for the resident can contribute to a fall.

The resident was at risk for a fall and injury when their falls prevention intervention was not appropriately applied.

Sources: Observations (two different occasions); resident #002's clinical records, interviews with RPN #113, PT, and DOC. [000707]